Waiver of Right to Appear - Disability Hearing					(DO NOT WRITE IN THIS SPACE)	
Name of (	Claimant					
Name of Wage Earner or Self-Employed			Social Security Number			
	(COMPLETE ONLY IN SUPPLEMENTAL SECUR		OME CASE)			
Name of Spouse			Social Security Number			
Туре	Disability				SSI	
of Benefit	Worker Widow/ Child		Disabilit	ty	Blind	Child
Name of F	Representative, if any		<u></u>	I		
Represen	atative Address			Telephone	e Number (Include Area Code)	
witnesses should no the disabi prevent m represent want to ap officer dea Security A	en advised of my right to have a disability hearing. s and explain in detail to the disability hearing office of end. I understand that this opportunity to be seen ility hearing officer would give me an opportunity to be from working and restrict my activities. I have be tation at a hearing by an attorney or other person of ppear at a disability hearing, or have someone repu- cide my case on the evidence of record plus any er Administration. I have been advised that if I change In this event, I can make the request with any Soc	er, who wil n and hear o present a een given a of my choic resent me vidence w e my mind	I decide my d could be e and question an explanati æ. Although at a disabilit hich I may s I can reque	case, the r effective in witnesses on of my ri the above ty hearing. ubmit or w	easons why m explaining the and explain h ght to represe has been exp I prefer to haw hich may be o	ny disability benefits facts in my case, since ow my impairments ntation, including lained to me, I do not ve the disability hearing btained by the Social
Signature (First Name, Middle Initial, Last Name) (Write in inl				Date (Month, Day, Year)		
				Telephone	e Number (Inc	lude Area Code)
Mailing Ad	ddress (Number and Street, Apt. No., P.O. Box, or	Rural Rou	ute)			
City and State					ZIP Co	ode
	s are required ONLY if this form has been signed b v the person requesting reconsideration must sign					vitnesses to the signing
1. Signature of Witness			2. Signature of Witness			
Address (Number and Street, City, State, ZIP Code)			Address (Number and Street, City, State, ZIP Code)			

## Privacy Act Statement Collection and Use of Privacy Information

Sections 205(a) and (b) and 1631(e)(1)(A) and (B) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent an accurate and timely decision on your waiver request.

We will use the information you provide to acknowledge your decision to waive the right to a disability hearing and to determine your waiver eligibility. We may also share the information for the following purposes, called routine uses:

- To contractors and other Federal Agencies, as necessary, for the purpose of assisting us in the efficient administration of our programs. We will disclose information under this routine use only in situations in which we may enter into a contractual or similar agreement to obtain assistance in accomplishing an SSA function relating to this system of records; and
- To student volunteers, individuals working under a personal services contract, and other workers who technically do not have the status of Federal Employees, when they are performing work for us, as authorized by law, and they need access to personally identifiable information (PII) in our records in order to perform their assigned agency functions.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0005, entitled Administrative Law Judge Working File on Claimant Cases, as published in the Federal Register (FR) on April 29, 2009, at 74 FR 19617; and 60-0089, entitled Claims Folders Systems, as published in the FR on October 31, 2019, at 84 FR 58422. Additional information, and a full listing of all our SORNs, is available on our website at <a href="https://www.ssa.gov/privacy">www.ssa.gov/privacy</a>.

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate or other aspects of this collection to this address, not the completed form.